Health Care Quality and Cost Enabling Statute

CHAPTER 6A. EXECUTIVE OFFICES
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
Chapter 6A: Section 16J. Definitions applicable to Secs. 16J to 16L

Section 16J. As used in this section and in sections 16K and 16L, the following words shall, unless the context clearly requires otherwise, have the following meanings:--

"Clinician", a health care professional licensed under chapter 112.

"Council", the health care quality and cost council, established by section 16K.

"Facility", a hospital, clinic or nursing home licensed under chapter 111 or a home health agency.

"Health care provider", a clinician, a facility or a physician group practice.

"Insurer", a carrier authorized to transact accident and health insurance under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a nonprofit medical service corporation licensed under chapter 176B, a dental service corporation organized under chapter 176E, an optometric service corporation organized under chapter 176F and a health maintenance organization licensed under chapter 176G.

"Physician group practice", 2 or more physicians who deliver patient care, make joint use of equipment and personnel and divide income by a prearranged formula.

[Definition of "Third party administrator" added by 2008, 305, Sec. 2 effective August 10, 2008.]

"Third party administrator", an entity that administers payments for health care services on behalf of a client plan in exchange for an administrative fee.

Chapter 6A: Section 16K. Health care quality and cost council

[Text of section as amended by 2008, 305, Sec. 3 effective August 10, 2008.]

Section 16K. (a) There shall be established a health care quality and cost council within, but not subject to control of, the executive office of health and human services. The council shall promote public transparency of the quality and cost of health care in the commonwealth, and shall seek to improve health care quality, reduce racial and ethnic health disparities and contain health care costs by: (i) disseminating health care quality and cost data to consumers, health care providers and insurers via a consumer health

information website pursuant to subsection (e) and (g); (ii) establishing quality improvement and cost containment goals pursuant to subsection (h); and (iii) establishing standard performance measures, quality performance benchmarks and statewide health information technology adoption goals for health care providers and insurers pursuant to subsection (i).

(b) The council shall consist of 16 members and shall be comprised of: (i) 9 ex-officio members, including the secretary of health and human services, who shall serve as the chair, the secretary of administration and finance, the state auditor, the inspector general, the attorney general, the commissioner of insurance, the commissioner of health care finance and policy, the commissioner of public health, and the executive director of the group insurance commission, or their designees; and (ii) 7 representatives of nongovernmental organizations be appointed by the governor, including 1 representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid Services, 1 representative of the Institute for Healthcare Improvement recommended by the organization's board of directors, 1 representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, 1 representative of the Massachusetts Association of Health Underwriters, Inc., 1 representative of the Massachusetts Medicaid Policy Institute, Inc., 1 expert in health care policy from a foundation or academic institution, and 1 representative of a non-governmental purchaser of health insurance. At least 1 member of the council shall be a clinician licensed to practice in the commonwealth. Members of the council shall be appointed for terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation, but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties which may include reimbursement for reasonable travel and living expenses while engaged in council business. Chapter 268A shall apply to all council members; provided, however, that the council may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in which any council member is in anyway interested or involved; provided further that such interest or involvement is disclosed in advance to the council and recorded in the minutes of the proceedings of the council; and provided further, that no council member having such interest or involvement may participate in any decision relating to such organization.

(c) All meetings of the council shall be in compliance with chapter 30A, except that the council, through its by-laws, may provide for executive sessions of the council. No action of the council shall be taken in an executive session.

The council may, subject to chapter 30B and subject to appropriation, procure equipment, office space, goods and services.

The council shall receive staff assistance from the executive office of health and human services and may, subject to appropriation, appoint an executive director and employ such additional staff or consultants as it deems necessary. The executive office shall provide administrative support to the council as requested.

The council shall promulgate rules and regulations and may adopt by-laws necessary for the administration and enforcement of this section.

(d) The council shall disseminate the data it collects under this section to consumers, health care providers and insurers through: (i) a publicly-accessible consumer health information website; (ii) reports on performance provided to health care providers; and (iii) any other analysis and reporting the council deems appropriate.

When collecting data, the council shall, to the extent possible, utilize existing public and private data sources and agency processes for data collection, analysis and technical assistance. The council may enter into an interagency service agreement with the division of health care finance and policy for data collection analysis and technical assistance.

The council may, subject to chapter 30B, contract with an independent health care organization for data collection, analysis or technical assistance related to its duties; provided, however, that the organization has a history of demonstrating the skill and expertise necessary to: (i) collect, analyze and aggregate data related to quality and cost across the health care system; (ii) identify quality improvement areas through data analysis; (iii) work with Medicare, MassHealth, and other insurers' data; (iv) collaborate in the design and implementation of quality improvement and clinical performance measures; (v) establish and maintain security measures necessary to maintain confidentiality and preserve the integrity of the data; and (vii) identify and, when necessary, develop appropriate measures of quality and cost for public reporting of quality and cost information.

Insurers and health care providers shall submit data to the council, to an independent health care organization with which the council has contracted, or to the division of health care finance and policy, as required by the council's regulations. The council, through its rules and regulations, may determine what type of data may reasonably be required and the format in which it shall be provided.

The council may request that third-party administrators submit data to the council, to an independent health care organization with which the council has contracted, or to the division of health care finance and policy. The council, through its rules and regulations, may determine the format in which the data shall be provided. The council shall publicly post a list of third-party administrators that refuse to submit requested data.

If any insurer or health care provider fails to submit required data to the council on a timely basis, the council shall provide written notice to the insurer or health care provider. An insurer or health care provider that fails, without just cause, to provide the required information within 2 weeks following receipt of the written notice may be required to pay a penalty of $1,000 for each week of delay; provided, however, that the maximum annual penalty under this section shall be $50,000.

(e) The council shall, in consultation with the advisory committee established by section 16L, establish and maintain a consumer health information website. The website shall

contain information comparing the quality and cost of health care services and may also contain general health care information as the council deems appropriate. The website shall be designed to assist consumers in making informed decisions regarding their medical care and informed choices among health care providers. Information shall be presented in a format that is understandable to the average consumer. The council shall take appropriate action to publicize the availability of its website.

The council shall, in consultation with its advisory committee, develop and adopt, on an annual basis, a reporting plan specifying the quality and cost measures to be included on the consumer health information website and the security measures used to maintain confidentiality and preserve the integrity of the data. In developing the reporting plan, the council, to the extent possible, shall collaborate with other organizations or state or federal agencies that develop, collect and publicly report health care quality and cost measures and the council shall give priority to those measures that are already available in the public domain. As part of the reporting plan, the council shall determine for each service the comparative information to be included on the consumer health information website, including whether to: (i) list services separately or as part of a group of related services; or (ii) combine the cost information for each facility and its affiliated clinicians and physician practices or to list facility and professional costs separately.

The council shall, after due consideration and public hearing, adopt or reject the reporting plan or any revisions. If the council rejects the reporting plan or any revisions, the council shall state its reasons for the rejection. The reporting plan and any revisions adopted by the council shall be promulgated by the council. The council shall submit the reporting plan and any periodic revisions to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and the clerks of the house and senate.

The website shall provide updated information on a regular basis, at least annually, and additional comparative quality and cost information shall be published as determined by the council, in consultation with the advisory committee. To the extent possible, the website shall include: (i) comparative quality information by facility, clinician or physician group practice for each service or category of service for which comparative cost information is provided; (ii) general information related to each service or category of service for which comparative information is provided; (iii) comparative quality information by facility, clinician or physician practice that is not service-specific, including information related to patient safety and satisfaction; and (iv) data concerning healthcare-acquired infections and serious reportable events reported under section 51H of chapter 111.

(f) The council, through its rules and regulations, shall provide access to data it collects pursuant to this section under conditions that: (i) protect patient privacy; (ii) prevent collusion or anti-competitive conduct; and (iii) prevent the release of data that could reasonably be expected to increase the cost of health care. The council may limit access to data based on its proposed use, the credentials of the requesting party, the type of data requested or other criteria required to make a determination regarding the appropriate

release of the data. The council shall also limit the requesting party's use and release of any data to which that party has been given access by the council. The council shall provide the division of health care finance and policy with a database of health care claims data submitted pursuant to this section under an interagency service agreement for the purpose of conducting data analysis and preparing reports to assist in the formulation of health care policy and the provision and purchase of health care services.

Data collected by the council under this section shall not be a public record under clause twenty-sixth of section 7 of chapter 4 or under chapter 66, except as specifically otherwise provided by the council.

The council shall, through interagency service agreements, allow the use of its data by other state agencies, including division of health care finance and policy, for review and evaluation of mandated health benefit proposals as required by section 38C of chapter 3.

(g) The council, in consultation with its advisory committee, shall disseminate to health care providers their individualized de-identified data, including comparisons with other health care providers on the quality, cost and other data to be published on the consumer health information website.

(h) The council, in consultation with its advisory committee, shall develop annual health care quality improvement and cost containment goals. The goals shall be designed to promote high-quality, safe, effective, timely, efficient, equitable and patient centered health care. The council shall also establish goals that are intended to reduce racial and ethnic health care disparities and in so doing shall seek to incorporate the recommendations of the health disparities council and the office of health equity. For each goal, the council shall: identify the steps needed to achieve the goal; estimate the cost of implementation; project the anticipated short-term or long-term financial savings achievable by the health care providers, insurers or the commonwealth: and estimate the expected improvements in the health status of health care consumers in the commonwealth. The council may recommend legislation or regulatory changes to achieve these goals.

(i) The council, in consultation with its advisory committee, relevant state agencies, and public and private health care organizations, shall develop and annually publish: (i) standard performance measures, including, common and consistent reporting of quality measures and common use of measures used for pay-for-performance reimbursement; (ii) quality performance benchmarks for health care providers and insurers that: (1) are clinically important, evidence-based, standardized and timely; (2) include both process and outcome measures; (3) encourage health care providers and insurers to improve health care quality; and (4) are developed based on the work of national organizations, including the National Quality Forum and the Hospitals Quality Alliance; and (iii) goals for statewide adoption of health information technology.

[There is no subsection (j).]

(k) The council shall conduct annual public hearings at which health care providers, insurers, relevant state agencies, and public and private health care organizations shall report their progress towards achieving the quality improvement and cost containment goals, adopting the standard performance measures and meeting the quality performance benchmarks. The council shall provide health care providers, insurers, state agencies and the general court with the following, at least 60 days prior to the public hearings: (i) recommended action required by each entity to achieve the specified quality and cost containment goals; and (ii) recommendations for adoption of each standard performance measure, quality performance benchmark and health information technology adoption goal established by the council.

(*l*) The council shall file a report, not less than annually, with the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and the clerks of the house and senate on its progress in achieving the goals of improving quality and containing or reducing health care costs data provided pursuant to chapter 111N. The report shall include, at a minimum, a review of the progress towards achieving the quality improvement and cost containment goals, adoption of standard performance measures, meeting the quality performance benchmarks, and achieving the health information technology adoption goals.

The council shall provide its advisory committee with reasonable opportunity to review and comment on all reports before their public release.

Reports of the council shall be published on the consumer health information website.

Chapter 6A: Section 16L. Advisory committee to the health care quality and cost council

[Text of section as amended by 2008, 305, Sec. 3 effective August 10, 2008.]

Section 16L. (a) There shall be established an advisory committee to the health care quality and cost council, established by section 16K, to allow the broadest possible involvement of the health care industry and others concerned about health care quality and cost.

(b) The advisory committee shall consist of at least 29 members to be appointed by the governor, 1 of whom shall be a representative of the Massachusetts Medical Society, 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts AFL-CIO Council, Inc., 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc., 1 of whom shall be a representative of Health Care For All, Inc., 1 of whom shall be a representative of the Massachusetts Public Health Association, 1 of whom shall be a representative of the Massachusetts Association of Behavioral Health Systems, Inc., 1 of whom shall be a representative of the Massachusetts Extended Care Federation, Inc., 1 of

whom shall be a representative of the Massachusetts Council of Human Service Providers, Inc., 1 of whom shall be a representative of the Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a representative of Associated Industries of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Business Roundtable, Inc., 1 of whom shall be a representative of the Massachusetts Taxpayers Foundation, 1 of whom shall be a representative of the Massachusetts chapter of the National Federation of Independent Business, 1 of whom shall be a representative of the Retailers Association of Massachusetts, 1 of whom shall be a representative of the Massachusetts Biotechnology Council, Inc., 1 of whom shall be a representative of the Blue Cross Blue Shield of Massachusetts Foundation, Inc., 1 of whom shall be a representative of the Massachusetts chapter of the American Association of Retired Persons, 1 of whom shall be a representative of the Massachusetts Coalition of Taft-Hartley Trust Funds, Inc., and additional members including, but not limited to, a representative of the mental health field, a representative of pediatric health care, a representative of primary health care, a representative of medical education, a representative of racial or ethnic minority groups concerned with health care, a representative of hospice care, a representative of the nursing profession and a representative of the pharmaceutical field. Members of the advisory committee shall be appointed for terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

(c) The members of the advisory committee shall annually elect a chair, vice chair and secretary and may adopt by-laws governing the affairs of the advisory committee.

(d) The advisory committee shall have the following duties: (i) advise the council on the consumer health information website and health care provider and insurer reports; (ii) advise the council on the annual health care quality improvement and cost containment goals, transparency standards and quality performance benchmarks; and (iii) review and comment on all reports of the council before public release, including the annual reporting plan and any revisions and the annual report to the general court.

(e) A written record of all meetings of the committee shall be maintained by the secretary and a copy filed within 15 days after each meeting with the council.